APPENDIX A

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Amendment VIII of the United States Constitution states "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

U.S.C.A. Const. Amend. VIII

Amendment XIV, Section 1 of the United States Constitution states as follows:

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S.C.A. Const. Amend. XIV

A civil action for deprivation of right in Title 42, Chapter 21 of the United States Code Annotated details, in pertinent part in 42 U.S.C.A. § 1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the

party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 U.S.C.A. § 1983.

APPENDIX B

Michael Leroy DOLIHITE, individually and as father and next friend of David Michael Dolihite; Joyce Mary Dolihite, Plaintiffs,

v.

Mary Fay VIDEON, as Executrix of the Estate of Robert Maughon, deceased; Royce G. King; R. Emmett Poundstone, III; Anthony R. Dykes; Bradley Mazick; Karen Jurls; Andrew McBride; Neuropsychiatry Associates, P.C.; Chester Jenkins; Medical Money Management, Inc., Defendants.

Civ. A. No. 92-H-1398-N.
United States District Court,
M.D. Alabama, N.D.

[Filed March 21, 1994]

ORDER

In accordance with the attached memorandum opinion summary judgment is GRANTED as to all defendants on all state claims. The court having determined that no defendant is entitled to qualified immunity on the federal claims, summary judgment is DENIED to all defendants on all federal claims.

Done this 21st day of March, 1994

/s/ TRUMAN HOBBS

TRUMAN HOBBS
United States District Judge

APPENDIX C

Michael Leroy DOLIHITE, Individually and as Father and Next Friend of David Michael Dolihite; Joyce Mary Dolihite, Individually, Plaintiffs-Appellees,

v.

Robert MAUGHON, M.D., Deceased, By and Through Mary Fay VIDEON, as Executrix of the Estate of Robert Maughon, M.D.; Royce G. King, Individually; R. Emmett Poundstone, III, Individually; Anthony R. Dykes, Individually; Bradley Mazick, Individually; Karen Jurls, Individually; Andrew McBride, Individually; Chester Jenkins, M.D.; Medical Money Management, Inc., Defendants-Appellants, The Alabama Department of Mental Health; Eufaula Adolescent Center; Neuropsychiatry Associates, P.C.; Medical Management, Inc., Defendants.

No. 94-6343.
United States Court of Appeals,
Eleventh Circuit.

Jan. 23, 1996.

Appeals from the United States District Court for the Middle District of Alabama

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Affirmed in part and reversed in part

Edmundson, Circuit Judge, dissented in part and concurred in result in part and filed opinion.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Civil Action No. 92-H-1398-N

MICHAEL LEROY DOLIHITE, father and next friend of David Michael Dolihite, et al. *Plaintiffs*

vs.

MARY FAY VIDEON, as Executrix of the Estate of Robert Maughon, deceased, et al *Defendants*

[Filed November 5, 1993]

ORDER

The pretrial hearing scheduled for October 28, 1993, is treated as a status conference. Pursuant to discussions at that conference, the court on its own motion continues this case for pretrial and trial until further notice. The parties are relieved of discovery deadlines; discovery will not be stayed.

During the status conference, plaintiffs moved this court to compel the production of the names of children in the male dormitory during the time that David Dolihite was a resident of the dormitory. Subsequent to the conference, plaintiffs notified the court of their desire to withdraw the motion to compel. Consequently, the motion to compel is DENIED as moot.

During the status conference, the court ORDERED plaintiffs to sharpen, to narrowly define, and to state with specificity each allegation that is brought against each defendant, the evidence that supports such allegation, and the evidence relied on by plaintiffs to rebut defendants' motion for summary judgment. The refined allegations and such evidence must be filed by November 19, 1993. Defendants are DIRECTED to respond to these sharpened allegations within ten days after they are filed with the court.

Pending before the court is plaintiffs' motion of July 23, 1993, to amend the complaint to add as a party defendant the Alabama Department of Mental Health. Plaintiffs contend that the Alabama Department of Mental Health is responsible for the medical bills that David Dolihite continues to incur. During the status conference the parties agreed that this matter should be tried in state court. Defendants agreed that they would raise no impediment by way of the statute of limitations or by way of a contention that the issue should have been litigated in federal court. Accordingly, the plaintiffs' motion to amend is DENIED as moot.

Done this 5th day of November, 1993.

/s/ TRUMAN HOBBS

TRUMAN HOBBS
United States District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Civil Action No. 92-H-1398-N

MICHAEL LEROY DOLIHITE, father and next friend of David Michael Dolihite, et al. *Plaintiffs*

vs.

MARY FAY VIDEON, as Executrix of the Estate of Robert Maughon, deceased, et al *Defendants*

[Filed November 22, 1993]

PLAINTIFF'S RESPONSE TO THIS
COURT'S ORDER
OF NOVEMBER 5, 1993

The following is submitted in response to this Court's Order of November 5, 1993. In addition to the below, Plaintiff continues to rely on the contentions set forth in Plaintiff's brief filed on July 21, 1993 and Brief filed on October 21, 1993, and all attachments thereto and all other documents which have been filed with the Court in opposition to Defendants' motions for summary judgment based on qualified immunity.

In their briefs, Plaintiff's set out a list of items upon which they relied in opposition to Defendants' motions for summary judgment. Plaintiff continues to rely on items One through Twenty-Seven which were attached to Plaintiff's initial brief and filed with the Court in three separate volumes. Plaintiff also continues to rely upon Exhibits One through Twelve and the brief attached thereto which were filed with the court on October 23, 1993. The Court has requested that the Plaintiff sharpen, narrowly define, and state with specificity each allegation that is brought against each Defendant, the evidence that supports each allegation and the evidence relied on by the Plaintiff to rebut Defendants' Motion for Summary Judgment. Of necessity, the information contained herein will be somewhat repetitious to that found in Plaintiff's July 21st and October 21st briefs and documents attached hereto. Plaintiff sets forth the following in compliance with the Court's Order.

Under the cases of Youngburg v., and Wyatt v Stickney, David Dolihite as an involuntarily, civilly committed mental patient, was to be afforded, among others, the following rights:

A. Safe conditions of confinement.

B. Freedom from bodily restraint.

C. Training and habilitation.

D. Adequate medical care.

E. Personal security.

F. Freedom from punishment.

G. Individual treatment as would give him a realistic opportunity to be cured or to improve his medical condition. (Treatment encompasses a humane physical and psychological environment.)

H. Freedom from mistreatment, neglect or abuse.

I. Treatment of serious medical needs.

Each of the above enumerated rights were violated by the Defendants in this case. The evidence upon which Plaintiff relies for these contentions are as follows:

A. EAC governing bylaws signed by Emmett Poundstone on 7/23/90 (Plaintiff's Exhibit one, Deposition of Defendants.)

B. The EAC suicide assessment and precaution policy and procedure (Plaintiff's Exhibit three to Defendant's deposition.) This evidence applies to Maughon, Jenkins, Mazick, Jurls, McBride and Dykes.

C. Wyatt Consultant Committee letter of December 1, 1989, from Thomas B. Stage, M.D. to Mr. James Reddoch, Deputy Commissioner, Department of Mental Health and Retardation. (Plaintiff's Exhibit two of Defendant's deposition) This evidence applies to King, Poundstone, and Dykes.

D. The Alabama Department of Mental Health and Retardation Know Your Rights Brochure (Plaintiff's Exhibit four of Defendant's deposition) This evidence applies to all Defendants.

E. The Wyatt Consultant Committee Report to the Court dated March 15, 1991, submitted by Robert Okin, M.D., Chairman, Thomas Stage, M.D., Cathy Sawyer, M.S.W., and Clarence J. Sundrum, J.D. (Plaintiff's Exhibit five to Deposition of Defendants.) This document applies to all defendants. On Page 6 under Roman numeral C, the document states as follows: "In the opinion of the Committee, accreditation by APPSC is not an adequate substitution for JCAHO accreditation." The document goes on to note that gross inadequacies existed in the charts, specifically in histories, the psychiatric examinations, the overall clinical assessments, and the treatment planning. In a number of charts randomly selected,

there was no history or clinical assessment at all, the psychiatric examination was totally inadequate and the treatment plans were "canned" and lacked any individualization. The document goes on further to state that the committee was "struck by the lack of sensitivity on the part of the treatment staff to the painful wounds these children were struggling with." Further, the document stated that in response to the concerns raised by the Committee and the Advocacy Program, Emmett Poundstone agreed to conduct a two month study of the use of restraints and seclusion at Eufaula and in particular the use of hard restraints. (Exhibit Memo of October 31, 1990.) At the time of the report, the Committee noted that it has no knowledge of whether these actions had been taken and if so, the result.

F. A May 14, 1990 letter from Robert L. Okin, M.D., Chairman of the Wyatt Committee to Commissioner to J. Michael Horsley, Alabama Department of Mental Health and Retardation, which states that the Committee had a "deeply disturbing day at Eufaula". The letter states that the Committee was distressed about what they viewed as real deficits in the facility. They observed gross inadequacies in the psychiatric examination and overall clinical assessment in treatment planning of the children. Further, they stated when they watched the interactions between the staff and the kids it was clear that the above deficiencies were not simply a result of problems and documentation but reflected deeper problems in the facility and in the staff's clinical understanding of the kids. (Plaintiff's Exhibit seven to deposition of Defendants) This evidence applies to all Defendants.

G. A May 22, 1990 letter from the Honorable Myron H. Thompson, United States District Judge to Mr. J. Michael Horsley, Commissioner, (Plaintiff's Exhibit eight to deposition of Defendants) in which he advises Mr.

Horsley that he recently met with the Wyatt Committee to discuss a number of matters. He was joined by Mr. James F. Reddoch, Jr., Mr. Rick Trawick, and Mr. Ira Burnham. The Court notes in the letter that it was informed by the Wyatt Committee of grave deficiencies observed in diagnostic assessments, individualized treatment planning, and the actual treatment being received by the children at Eufaula. It was further stated in the letter that it was agreed at the meeting held there in the Judge's chambers that the Department should develop by no later than mid-August, 1990, a detailed plan providing both a conceptual framework for children's mental health services and an operational plan to develop need based community services to end placements at Eufaula. This evidence goes to the liability of all Defendants.

H. The Wyatt Consultant Committee memorandum to Commissioner Horsley, the Wyatt Committee, Ira Burnham, Rick Trawick, Jim Reddoch, Emmett Poundstone, Brian McManus, and Larry Latham, from Robert L. Okin, M.D., Chairman of the Wyatt Committee, dated October 31, 1990 (Plaintiff Exhibit ten to deposition of defendants), regarding Exit Memo from the Committee's October meeting with the Department. This memorandum on page three addresses Eufaula Adolescent Center and found the use of seclusion and restraint was being inappropriately used at Eufaula. Emmett Poundstone agreed to study the last two months of seclusion and restraint. The study would state that for each client who was secluded or restrained there would be an identification of the client, why he was secluded or restrained, for how long, what less restrictive intervention was attempted before seclusion and restraint was ordered, and for kids who were secluded or restrained multiple times, what treatment plan was developed to avert this in the future. (There is no evidence that such a re-

port was made.) The Exit memo also stated that it was agreed by the Wyatt Committee that Dr. Laymon and Dr. Buzogany will serve as consultants to review the population at Eufaula for appropriateness and will determine what services and settings each of the kids require. They will also review the quality of the program at Eufaula and make specific recommendation to the Commissioner for improvements. (There is no evidence that such a report was conducted.) This goes to the liability of King, Poundstone, and Dykes.

I. September 14, 1988 memo to James Pouncy from Cathy Sawyer regarding the Eufaula monitoring. (Plaintiff's Exhibit eleven to Defendant's depositions) The memo documents that as far back as 1988 it was known that seclusion was being inappropriately used at Eufaula Adolescent Center.

J. November 29, 1990 letter to the Honorable Judge Myron H. Thompson from Dr. Robert L. Okin, M.D. The letter states that Dr. Laymon, one of the consultants at the Department of Mental Health brought in to do assessments at Eufaula, was advised by the Department that he and Dr. Buzogany should have no direct communication with the Wyatt Consultant Committee and that this was in explicit violation of the agreements that were arrived at in the Judge's office. The letter goes on to advise the Court that in Dr. Okin's opinion, the task the Department had given the Eufaula consultants was an inappropriately narrow one: to assess the kids at Eufaula for the purpose of determining what improvements needed to be made at the institution. Dr. Okin states:

> This is in total disregard of the commitments that were made to you, (Judge Thompson) by the Department that they would look first at the larger issue: what services and treatment settings these kids needed outside or inside

Eufaula. This was to lead to a service development plan that could divert many kids from Eufaula. It was also to lead to an informed conclusion as to the future of Eufaula. "Obviously the Department wishes to avoid the question altogether, apparently preferring to protect Eufaula rather than the kids." This goes to the liability of King and Poundstone and Dykes.

K. A letter of resignation from Bradley Mazick to Anthony Dykes, dated June 15, 1992. The letter states, among other things, that Mr. Dykes had received a negative review by the AAPSC surveyors as the clinical director of Eufaula Adolescent Center. He states he believes he rose above his "limited level of experience coming into the job and the minimal amount of training and lateral support he had while he was there." (Plaintiff's Exhibit sixteen to the depositions of Defendants) This applies to the liability of King, Poundstone, Dykes and Mazick.

L. EAC's policy and procedure regarding the restriction of residents (Plaintiff's Exhibit nineteen to the deposition of Defendants.) This document goes to the liability of all Defendants.

M. EAC's policy and procedure regarding treatment teams. This document states that the psychiatrist will be considered a member of all treatment teams. (Plaintiff's Exhibit twenty to deposition of Defendants.) This applies to the liability of all Defendants, but especially Jenkins and Maughon.

N. EAC's policy and procedure on facility accreditation which states that it shall be the policy of the Eufaula Adolescent Center to attain accreditation by the American Association of Psychiatric Services for children. (This is inconsistent with the agreements and directives set out in the consent decree entered in the Wyatt litigation by Judge Thompson.) (Plaintiff's Exhibit twenty-three to depositions of Defendants)

O. EAC's policy and procedure on professional services. (Plaintiff's Exhibit twenty-four to depositions of Defendants) This document sets out the admission processes and definitions of the various levels of problems that may or may not be treated at Eufaula Adolescent Center. This document makes it clear that an actively suicidal adolescent is not appropriate as a patient at Eufaula Adolescent Center. This document applies to the liability of all Defendants.

P. EAC's policy on core curriculum, mental health worker 1 classification. (Plaintiff's Exhibit twenty-five to depositions of Defendants) This document among other things lists the basic orientation, the Wyatt v Stickney court order and the patient bill of rights. This document applies to the liability of all Defendants and demonstrates their knowledge of the Wyatt v Stickney requirements.

Q. EAC's policy on admission criteria, (Plaintiff's Exhibit twenty-six to deposition of Defendants) which states that the currently actively suicidal adolescent is not appropriate for initial placement at Eufaula.

R. Baldwin County Mental Health Center psychological evaluation conducted on David Dolihite on 8/26/1991, for referral to Eufaula Adolescent Center. (Plaintiff's Exhibit thirty-five to depositions of Defendants) This document states among other things "David appeared to have an obsession with writing poetry with themes of death. He threatened suicide in March of 1991, giving a poem to his former girlfriend describing his death." The evaluation goes on to state that David was having difficulty sleeping at night, he describes looking in the mirror and seeing no reflection, seeing hands beckoning to him, and seeing the ghost of someone killed in a car wreck. He reports obsession with death and darkness and lyrics from heavy metal songs. (This is

consistent with psychotic behavior as well as suicidal behavior which would have made David an individual that would not have been a candidate at Eufaula Adolescent Center.) This document goes to the liability of Dykes, Mazick, Jurls, McBride, Maughon and Jenkins.

S. A January 9, 1992 letter to Terry Hanson from Ann L. Mathis, the admissions officer at Eufaula Adolescent Center and approved by Anthony Dykes indicating that they had reviewed the information on David (which would have included the Baldwin County Health information) and he has been accepted for placement at the facility. This applies to the liability of Dykes, Maughon, Jurls, McBride, Jenkins and Mazick.

T. Baldwin County Juvenile Court file on David Dolihite. (This goes to the liability of all Defendants and is Exhibit one to Plaintiff's Reply Brief of October 21, 1993.)

U. Eufaula Adolescent Center records regarding civil commitment. (This applies to the liability of Defendant Dykes and is Plaintiff's Exhibit two to their brief of October 21, 1993.)

V. Deposition testimony of Michael and Joyce Dolihite. (This applies to the liability of all Defendants and is Exhibit three to the October 21, 1993 brief of Plaintiffs.)

W. February 28, 1972 order of Judge Johnson. (This applies to the liability of all Defendants and is Plaintiff's Exhibit four to the reply brief of October 21, 1993.)

X. Order of Judge Myron Thompson of January 12, 1993, and is attached as Plaintiff's Exhibit five to the October 21, 1993 brief of Plaintiffs.

Y. The Consent Decree and accompanying memorandum Order of Judge Myron Thompson of 1986, WL

69194, and is attached as Plaintiff's Exhibit six to Plaintiffs' Reply Brief of October 21, 1993. This goes to the liability of all Defendants.

Z. The personnel records of Eufaula Adolescent Center which is Plaintiff's Exhibit seven in Plaintiffs' Reply Brief of October 21, 1993.

AA. Deposition of McBride and is Plaintiff's Exhibit nine to the Reply Brief of October 21, 1993.

BB. Deposition of Karen Jurls, Plaintiff's Exhibit eleven to the Reply Brief of October 21, 1993.

CC. Deposition testimony of Jenkins, Plaintiff's Exhibit twelve to the Reply Brief of October 21, 1993.

DD. The affidavit of Dr. Abraham L. Halpern of June 21, 1993, and November 19, 1993.

EE. The affidavit of Dr. Fletcher Hamilton of June 21, 1993, and Plaintiff's Exhibit two to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

FF. The affidavit of Alan Issacson, Plaintiff's Exhibit three to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

GG. The affidavit of John Fowler, Plaintiff's Exhibit four to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

HH. The affidavit of Billy Kirby, Plaintiff's Exhibit five to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

II. The sworn statement of Allen Forte, Plaintiff's Exhibit six to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

JJ. The written report for the Fiscal Year of 1991-1992 of the Annual Advocacy Monitoring, Plaintiff's Exhibit seven to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

KK. The entire depositions of Royce King, Emmett Poundstone, Anthony Dykes, Bradley Mazick, and Karen Jurls, Plaintiff's Exhibit eight to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

LL. Photographs of the seclusion area, Plaintiff's Exhibit nine of the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

MM. The mental illness policy signed by R. Emmett Poundstone on 7/23/90, Plaintiff's Exhibit ten to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

NN. Letter to Karen Jurls of March 17, 1992 from Brad Mazick, Ph.D., Plaintiff's Exhibit nineteen to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

OO. Investigation Report of Case number M15-8629-92 by Richard Corner to Anthony Dykes of July 17, 1992, Plaintiff's Exhibit twenty-four to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

PP. The contracts of Medical Money Management for Jenkins and Maughon, Plaintiff's Exhibit twenty-six to the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

QQ. The records of Eufaula Adolescent Center concerning David Dolihite, Plaintiff's Exhibit twenty-seven of

the Plaintiff's Response in Opposition to Defendant's Motion for Summary Judgment, of October 21, 1993.

The specific allegations with respect to each individual Defendant are as follows:

ROYCE KING

1. Royce King was the Commission of the Alabama Department of Mental Health at the time of David's suicide attempt. Royce King was at the time a policy making administrator. King and his subordinates, Poundstone, Dykes, Mazick, Maughon, Jenkins, Jurls and McBride exhibited such a degree of indifference to compliance with the policies of the Alabama Department of Mental Health and Retardation, as to demonstrate that they did not base actual administrative decisions or actions on professional judgment embodied in the policies.

2. Commissioner King knew he was responsible for compliance with the Wyatt standards. (Deposition of King at 37-38.) The specific allegations with regard to his responsibility in this light and his abdication of that responsibility is set out specifically in Plaintiff's initial brief on pages eleven through sixteen, a copy of which is attached hereto. In addition, Plaintiff asserts the following specific allegations.

3. King knew or had reason to know the children at Eufaula Adolescent Center were being subjected to abuse including David. This is evidenced by the internal advocacy reports submitted by Kathy Sawyer, and the Wyatt Committee report. King took no action to stop such abuse.

4. King knew or had reason to know the children were being secluded under improper conditions. (Annual Advocacy Reports of Kathy Sawyer for 1990-1991, 1991-1992, and the Wyatt Committee Reports) King took no action to stop this abuse.

5. King knew the consent order entered into by DMH&R and the Wyatt Plaintiffs in 1986 required Eufaula to work toward JCAHO accreditation. An action which would have of necessity put an end to abuse of patients and inhumane seclusion conditions. He further knew that the Wyatt Committee found accreditation by AAPC unacceptable. King made no effort to comply with the consent order. (Consent Order of 1986 and Depo. of King and Poundstone.)

6. King knew the Department had agreed to work out a program to evaluate the placement of these children, which would have included David, at Eufaula and that this agreement had been made in Judge Thompson's chambers but he did nothing to follow through.

EMMETT POUNDSTONE

The same standard that applies to King also applies to Associate Commissioner Emmett Poundstone. Emmett Poundstone was the Associate Commissioner for Mental Health which included supervision of Eufaula Adolescent Center. Emmett Poundstone, as indicated in Plaintiff's brief, was intimately familiar with the Wyatt v Stickney litigation and was intimately familiar with the constitutional requirements of Youngburg v as well as Wyatt v Stickney. Emmett Poundstone had visited Eufaula Adolescent Center and had participated in the Wyatt Committee review of Eufaula Adolescent Center and was thoroughly familiar with the conditions at Eufaula and the deficiencies which had been noted by the Wyatt Committee. The Wyatt Committee noted deficiencies in psychiatric evaluation, documentation of records, and overall treatment by the staff of the patients. Mr. Poundstone was aware of this. In addition, Mr. Poundstone failed to comply with the Federal Court directive that Eufaula Adolescent Center make all efforts to become accredited

by JCAHO. As Mr. Poundstone stated in his deposition, no efforts were made to follow up on the Court's directive. This allegation is significant with regard to the causation of David Dolihite in that if the JCAHO standards had been complied with, the facility at Eufaula Adolescent Center would have not been allowed to exist as it did at the time the Plaintiff was so severely injured. Mr. Poundstone allowed seclusion area in Building 112 to continue to be used for seclusion of patients. Mr. Poundstone testified in his deposition that he knew of the seclusion area in Building 112. Mr. Poundstone, thus, had to know that the seclusion area constituted inhumane conditions and placement of any patient in such conditions would violate the Wyatt v Stickney mandates and Youngburg v Romeo. Mr. Poundstone admits his responsibilities as Associate Commissioner for Mental Health encompassed making sure the constitutional standards that apply to Eufaula Adolescent Center were enforced. Poundstone failed to make sure the constitutional standards that applied to Eufaula Adolescent Center were enforced. Poundstone failed to make sure that beatings did not take place at Eufaula Adolescent Center. Poundstone had information through the Advocacy reports that beatings were taking place at Eufaula. Poundstone had information that beatings were taking place at Eufaula because he also had access to the complaints that were filled out by the children at Eufaula. Poundstone knew that seclusion in Building 112 would be tantamount to being secluded for punitive purposes. He knew or should have known that seclusion in Building 112 could have no therapeutic effect for these children.

Poundstone failed to direct that training be required by the Alabama Department of Mental Health for health care providers to be trained in suicide assessment in order to work with the youth at Eufaula Adolescent Center.

This is true even though Mr. Poundstone admitted that he agreed with the Eufaula Adolescent Center statement that Eufaula Adolescent Center recognizes that suicide is the second leading cause of death among adolescents in the general public and that its emotionally disturbed target population stands an even greater risk for self-destructive behavior. Emmett Poundstone was acutely aware of the deficiencies at Eufaula Adolescent Center with regard to the manner and method in which the psychiatric assessments were performed, and the manner and method in which the staff treated the patients. Emmett Poundstone knew or had reason to know that those deficiencies were in existence at the time of the incident made the basis of this lawsuit. Emmett Poundstone knew that Eufaula Adolescent Center had not complied with the 1986 Consent Decree of Judge Thompson which required the Alabama Department of Mental Health to work for JCAHO accreditation. Mr. Poundstone caused or contributed to the injury of David Dolihite by failing to protect David Dolihite's constitutional right to have personal security, to be free from punishment, to have individual treatment as will give him the realistic opportunity to be cured or improve his medical condition and the right to be free of mistreatment, neglect or abuse. The evidence which supports the above: The Wyatt Committee Report; The Letters from the Wyatt Committee to Judge Thomas and Commissioner Horlsey, the depositions of all defendants; the Annual Advocacy Report; and the Affidavits of Fowler, Kirby, Halpern, Hamilton, Isaacson and Forte.

ANTHONY DYKES

Dykes violated David's constitutional rights as follows: Dykes was responsible for making sure there were safe conditions of confinement at Eufaula Adolescent Center

and he failed to do so. Dykes was responsible to make sure David was free from unnecessary bodily restraints and he failed to do so. Dykes was responsible to make sure there was adequate medical care, including psychiatric medical care, available to the patients at the facility, including David, and he failed to do so. Dykes was responsible to make sure that David had personal security while at the facility and he failed to do so. Dykes was responsible to make sure David was free from punishment and he failed to do so. Dykes was responsible to make sure David received individual treatment as would give him the realistic opportunity to be cured or to improve his medical condition and he failed to do so. Dykes had a responsibility to make sure David was free of mistreatment, neglect, or abuse and he failed to do so.

The manner and method in which Dykes violated these constitutional rights is as follows: Dykes knew that David Dolihite was extremely high risk for suicide and allowed the conditions in the dormitory to be such as to give this child easy access to an environment in which he could make such an attempt. (It is notable that the closet in which both David Dolihite and Eddie Weidinger hung themselves were easily transformed from a dangerous, unsafe condition, to a condition where the children could not get in the closet and hang themselves. This was simply by replacing the rungs with shelves.) Dykes violated David's right to freedom from bodily restraint in that a review of David's medical records demonstrates that David was on many occasions restrained not for therapeutic reasons, but for reasons of punishment thinly veiled as therapeutic. This is evidenced by the medical records, and the affidavit of Dr. Halpern as well as the policy and procedure of the Eufaula Adolescent Center on restraints.

David did not receive adequate psychiatric medical care as evidenced by the fact that regardless of his re-

peated signs and symptoms of an active suicidal nature, self-mutilation behavior, and psychotic activity, he was not seen by a psychiatrist until five days before his suicide attempt. (An exception would be the admission assessment performed by Maughon when David first arrived.) (Records of David Dolihite and Affidavit of Halpern)

Dykes as the Center's Director was responsible for making sure the dormitories and dormitory managers did not abuse the patients and did not allow the patients to abuse one another. It is clear that Dykes knew or had reason to know that such abuse was going on and that David was a victim of such abuse. However, as the Annual Advocacy Monitor Report of Kathy Sawyer indicates, there was simply a rubber stamp procedure with regard to investigating complaints of abuse on the part of staff against residents and little if any effort was made to curb this activity. (Evidenced by medical records of David Dolihite, Annual Advocacy Monitor Report, sworn statement of Allen Forte, affidavit of Billy Kirby and John Fowler.)

Dykes as director of Eufaula Adolescent Center was a policy making administrator. He administered the Center and set policy and procedures for the Center as evidenced by the EAC policies and procedures, all of which are signed by Dykes. As a policy making administrator he is liable for the constitutional deprivations caused by his subordinates at EAC because as the evidence clearly demonstrates the subordinates under Dykes and Dykes himself exhibited such a degree of indifference to compliance with the Center policies as to demonstrate that they did not base their actual administrator decisions or actions on professional judgement embodied in the policy.

Dykes knew or had reason to know the dorm staff were abusing the patients (Report of Kathy Sawyer, Affidavit of Billy Kirby, Affidavit of John Fowler, and Statement of Allen Forte) He took no substantive action to enforce the

EAC policy that patients were not to be abused. Dykes was personally responsible for making sure proper investigations were conducted with respect to abuse of patients by staff. He failed to perform timely and accurate investigations. Dykes was personally responsible for allowing children including David Dolihite to be secluded in the inhuman conditions found in Building 112. He had the authority to direct that these rooms not be used for seclusion.

Dykes knew or had reason to know that time-out and other restriction measures were being used in a manner which was tantamount to punishment. He allowed this practice by the dorm staff to continue. (EAC records of David Dolihite, Affidavit of Billy Kirby, Affidavit of John Fowler and Wyatt Committee documents) Such practice contributed to the unsafe and insecure environment which existed at Eufaula Adolescent Center.

Dykes knew gangs existed at Eufaula Adolescent Center. He instituted no remedial program to alleviate this problem and the threat it proved to the children. (Deposition of Karen Jurls, medical records of David Dolihite, Affidavit of Billy Kirby and Affidavit of John Fowler)

Thus, Anthony Dykes is responsible both from the standpoint as a policy making administrator and from his responsibility for personal action for

1. Allowing abuse of David by staff and patient;
2. Failure to provide a secure human environment;
3. Allowing restraint which was tantamount to punishment;
4. Allowing conditions at EAC to create conditions of fear and intimidation as the part of patients which resulted in David's case in deterioration of his condition rather than improvement.
5. It was Dykes responsibility to provide a safe and humane environment for the children. The seclu-

sion rooms and the abusive behavior by the staff to the patients did not provide such an environment.

BRADLEY MAZICK

Dr. Mazick as the clinical director of EAC was a policymaking administrator. He set and administered clinical policy at the center. (Deposition of Mazick). As such, Mazick is not only liable for his personal actions which constituted violations of David's constitutional rights but like King, Poundstone and Dykes is responsible for the indifference to compliance with EAC policy in his clinical policy. In the instant case the degree of indifference is so substantial as to demonstrate that the clinical staff did not base their actual administrative decisions or actions on professional judgment embodied in the policy. (EAC policy and procedure regarding suicide assessment, EAC policy regarding restraint, Affidavits of Kirby, Fawler, Statement of Fortee, Deposition of all defendants, Annual Advocacy Report by Kathy Sawyer, Affidavit of Dr. Fletcher Hamilton, Affidavits of Dr. A.L. Halpin.) Mazick had an individual responsibility to David apart from his administrative role.

As the clinical director Mazick was responsible for making sure David was timely and properly assessed and treated from a clinical standpoint. He was in charge of supervising the activities of Maughon, Jenkins, Jurls and McBride. (Deposition of Mazick).

Dr. Mazick's treatment of David was a total departure from the most basic professional standpoint.

Dr. Mazick knew of David's suicidal condition yet he failed to request necessary and essential psychiatric treatment for David's condition. He failed to supervise David's therapist, Jurls, concerning David's condition. He failed to review David's clinical course on a regular basis

despite the fact that he had knowledge of David's suicidal condition. He never even reviewed David's chart until one hour before his death. The above is evidenced by the deposition of Dr. Mazick, David's records from EAC, the deposition of all other defendants, the affidavit of Dr. Fletcher Hamilton.

Defendant Mazick was responsible for constitutional violations regarding David's treatment by allowing David to be subjected to the inhuman conditions in building 112, a building which photographs and affidavit testimony demonstrate as inhuman. He knew children were secluded there. He knew the conditions. He allowed it to continue to be used.

Defendant Mazick was responsible for constitutional violations with respect to the manner and method in which time out and other forms of restriction was used on David. He knew or should have known that the time out was tantamount to punishment. He also knew or had reason to know the children including David were left in time out for excessive periods of time far in excess of any therapeutic intervention.

Mazick knew the children were being beaten and abused by the dorm staff and knew this was a violation of Watt v. Stickney court order. He took no remedial action to stop such actions. (Affidavit of Fawler, Kirby and Fortee).

Mazick failed to monitor the amount of therapeutic intervention David was getting and did nothing to require that he get sufficient therapeutic intervention to allow his condition to improve. To the contrary the environment in which David lived and lack of therapy caused his condition to deteriorate. (Affidavit of Fletcher Hamilton).

Contrary to Mazick's counsel assertions in his brief that plaintiff is only alleging Medical Malpractice against Dr. Mazick it is clear from the above that:

1. Mazick's treatment of David was a total departure from the most basic professional standard. Thus Mazick failed to provide the most basic medical needs of David.

2. Mazick's treatment or lack thereof deprived David of an opportunity to improve his mental health and in fact caused it to deteriorate (Affidavit of Halper of November 18, 1993).

3. As clinical director, Mazick failed to take remedial action regarding the use of Building 112 and thus subjected David to inhuman conditions.

4. As clinical director, Mazick knew David was being beaten and abused and/or subjected to an unsafe intimidating environment yet took no remedial action.

CHESTER JENKINS AND ROBERT MAUGHON

In the case of David Dolihite, Jenkins and Maughon did not provide adequate medical care from a psychiatric standpoint to David Dolihite. Their treatment, of lack thereof, of David was such a total departure from accepted professional judgment, practice or standards, such that it cannot be said that their treatment of David was based on accepted professional judgment of psychiatric practice in the same general community. The lack of attention evident in David's records by these psychiatrists make it evident that their conduct demonstrated deliberate indifference to the serious medical needs of this child.

David had a history of family suicide. David made prior suicidal threats and attempts by his own reports. Dr. Maughon knew this and Dr. Jenkins should have known this, had he conducted a proper review of David's records. David's obvious signs and symptoms of clinical

depression and bipolar disorder went undiagnosed. These doctors made no attempt to properly evaluate and treat David for these obvious mental disorders.

These doctors were part of David's treatment team and thus knew or should have known of the increasing episodes of self-mutilation, disruptive behavior, mood swings, psychotic episodes, and suicide attempts which took place over the seventy (70) days in which David was a patient at the Eufaula Adolescent Center. Having this knowledge, these psychiatrists should have prescribed intense one-on-one psychotherapy for David, making sure he received intense and lengthy individual therapy. Further, they should have prescribed anti-depressant medication for this child and should have carefully observed, monitored and noted his response or lack thereof to such medication. None of the above was done by either Dr. Jenkins or Dr. Maughon. Dr. Maughon saw David when he signed the admitting order. There is absolutely no evidence in the record that he ever saw David on even one occasion after that to evaluate David's psychiatric condition until March 19th when he saw him only after a medical doctor at Lakeview Community Hospital ordered that David must be evaluated for anti-psychotic medication.

There was a reported psychotic episode which was documented in David's records on February 18, 1992, where David was reported to be talking to himself and advised the nurse that he was talking to "a friend who told him what to do." On March 8, 1992, it was noted in his record that David intentionally cut his arm and required sutures in the Emergency Room. Dr. Jenkins was notified of this incident on the very day it occurred and was notified that David was making threats of suicide. Neither Dr. Jenkins nor Dr. Maughon bothered to see this child concerning this serious matter, Dr. Jenkins simply ordered medications over the telephone. Dr. Jenkins

was again notified of a serious episode regarding David on March 8, 1992, but again failed to see this child. He simply ordered over the phone soft restraints to be used on David.

On March 15th, David was secluded for bleeding on the walls and defecating on the floor, clearly signs of severe mental disturbance in this child. Neither Dr. Jenkins nor Dr. Maughon saw David for this extreme behavior. Dr. Maughon finally saw David on March 19, 1992, after the doctor at Lakeview ordered that he must be evaluated for anti-psychotic behavior. At the time, Dr. Maughon saw David on this occasion, however, he did no testing or in-depth evaluation of David's condition. He clearly made no effort to fully evaluate David's medical history during his stay at Eufaula Adolescent Center for he made no record of this in his progress note. Had Dr. Maughon properly conducted such a review, he could not, within any degree of professional standard, have arrived at the opinion expressed in his note that David's problems seemed to be behavioral.

A review of Dr. Maughon's note clearly indicates that there was no contact made by Dr. Maughon with the medical doctor who requested that David be evaluated. There was no effort on the part of Dr. Maughon to perform any tests of standard psychiatric evaluation of David. Dr. Maughon's record of his evaluation consists of one line which simply states, "This young man has been engaging in self-destructive behavior"; "his difficulty seems to be behavioral".

The above is a total departure from the professional judgment and standard which should have been followed in this instance. A carefully documented, in-depth psychiatric assessment should have been performed on David at this point with follow up treatment and evaluation. The medical doctor should have been consulted and a review

of David's entire medical chart performed in order to assess changes, e.g., deterioration in David's condition.

On March 21st, David was again placed in seclusion. The record notes that David was beating and banging his head on the wall and cursing loudly and totally out of control. In view of this child's recent history of suicide attempts, psychotic behavior, and the signs and symptoms evident in the record of the deterioration in David's condition since his arrival at Eufaula, this child should have been seen by Dr. Maughon or Jenkins when this report was received by Dr. Jenkins, or at the very least, one of these doctors should have seen David shortly after this report was issued. Yet, David was not seen by a psychiatrist, nor did the psychiatrist even ask the Ph.D. psychologist to see David.

In addition to the lack of attention on the part of the psychiatrists to the serious medical needs of David and their total departure from accepted medical judgment, practice or standards, David's condition and ultimate suicide attempt was also contributed to by the conditions of intimidation, abuse, neglect and punitive treatment which he was subjected to by the staff and other patients while at Eufaula Adolescent Center.

The sworn statements and depositions indicate that David was beaten and abused by both staff and other patients. Further, a review of his medical charts indicate that on many occasions, time-out and restriction was not used in David's case for legitimate therapeutic purposes, but rather was tantamount to punishment. The seclusion room David was put into in Building 112 in no way comports with therapeutic purposes but is rather simply a jail cell, which as viewed in the photographs, constitutes conditions that would cause severe deterioration in the mental condition of any patient subjected to such an inhumane environment.

1. Dr. Jenkins' and Dr. Maughon's treatment of this child was such a total departure from accepted professional judgment, practice or standards, that it cannot be said that their treatment was based on accepted professional judgment of psychiatric practice in the same general community.
2. As a result of the departure from accepted professional judgment on the part of these psychiatrists, David was not given necessary and essential individual treatment to afford him a realistic opportunity to be cured or to improve his mental condition.
3. That the lack of treatment by Dr. Jenkins and Dr. Maughon demonstrated deliberate indifference to the serious medical needs of this child.
4. That as a result of this lack of treatment combined with the abuse, neglect, intimidation and fear for his personal security to which David was subjected, David's condition deteriorated significantly while he was a patient at Eufaula Adolescent Center.
5. That within a reasonable degree of medical probability, had David received the necessary and essential treatment from the staff and psychiatrists and had he not been subjected to the atmosphere of abuse, neglect, and intimidation at Eufaula Adolescent Center, David's condition would not have deteriorated in the manner that it did and his ultimate suicide attempt would not have occurred when it occurred.
6. That it was a combination of the above factors, i.e., the lack of treatment on the part of the psychiatrists, the lack of treatment on the part of the staff and the intimidating abusive and insecure conditions at Eufaula, which ultimately caused the deteriorating condition of David's mental health

and his ultimate suicide attempt for which he is so devastatingly injured.

In support of the above, plaintiff relies on the medical records of David Dolihite, the first and second Affidavit of Dr. Halpern, the deposition of Dr. Jenkins, and the contracts of Medical Money Management.

KAREN JURLS

Defendant, Karen Jurls, was David's Primary Therapist. As such, she violated David's constitutional rights by failing to meet the most basic professional standards in the evaluation, assessment and treatment of David. (Affidavit of Allen Isaacson) She knew David was suicidal and knew or had reason to know that on the night of March 21, 1993 he had attempted to hang himself. Yet she failed to take any action with respect to David's attempt. (Medical records of David Dolihite, Statement of Allen Forte and Affidavits of Billy Kirby and John Fowler) She provided David only three hours of individual therapy and six hours of group therapy during the entire seventy-two day period he was a patient at Eufaula Adolescent Center.

On many occasions with respect to David, her "therapeutic interventions were tantamount to punishment e.g. when David wrote on the security screen he wanted to die. The only therapeutic" intervention he received was work rectitution for spoiling the security screen. One only need to review David's record to see that as David desperation increased he received no help but punishment. While, as stated above, Jurls provided David with only three and one-half hours of individual therapy in seventy-two days he was secluded for a period of fourteen hours, was on dorm restriction for ten days and kept in time-out for a total of sixty-four hours. Such treatment;

1. Did not provide David any reasonable opportunity to have an improvement in his mental health;

2. Deprived him of a safe, secure and humane environment; and
3. Resulted in restraint which equaled to punishment.

Defendant, Karen Jurls, failed to properly assess David on the day he attempted suicide. Had she done so, she would have known from reviewing his chart he had been secluded for attempting to hang himself. Defendant Jurls statement that she did not know this is clearly revealed by the record itself. Jurls failed to meet the most basis serious medical needs of David by failing to obtain intervention necessary to address David's serious mental problems. The evidence in support of the above is the Affidavit of Fowler and Kirby which indicates Jurls knew that David was threatened and intimidated by staff and patients. They also indicate she knew of David's attempt to hang himself on the 21st of March, the medical records of David, depositions of all defendants and the plaintiffs.

ANDREW McBRIDE

McBride was actively involved in David's care along with Jurls and Mazick and equally neglected his responsibility with regard to providing basic mental health needs of this child. McBride has worked at the Eufaula Adolescent Center since September of 1987 as a psychologist. He was a psychologist on David's treatment team. When David first arrived at Eufaula Adolescent Center, McBride did an initial intake, interviewed David, and reviewed his psychological evaluations. McBride knew David was suicidal when he arrived at the Center. (Depo of McBride at 7 and 8.) According to McBride, the treatment team met and discussed David Dolihite and every week. This included Dr. Jenkins and Dr. Maughon. (Depo of McBride at 9.) As part of the treatment team, McBride knew of David's suicidal ideations. McBride also

knew of the seclusions, dorm restrictions, and the time outs. McBride knew about the cells in Building 112 and as a member of the treatment team, McBride would have had a responsibility to review David's medical records and was aware that David was injuring himself and threatening suicide.

McBride saw David on Monday morning after the initial attempt to hang himself which was reported by Mr. Forte. McBride did not do a suicide assessment on David at that time. (Depo of McBride 28 - 32.) McBride admits that the entry concerning the actions that children take in time out are normally reported to them. McBride admits this information is important. McBride admits this information is usually provided at Monday morning community meetings. (Depo at 34.) McBride was informed that David had been secluded the weekend before and saw the progress report involving same. McBride, however, did no suicide assessment. (Depo of McBride at 35, 36, and record of David.) McBride knew that David had been in time out just prior to seclusion. He failed, however, to review the time out sheet to determine what had gone on in the time out room prior to David being secluded for attempting to injure himself. McBride did not engage David in any individual therapy after this episode.

McBride admits that if a child expresses the thought and intent to commit suicide, that makes them actively suicidal. (McBride at 43.) Clearly, David was an actively suicidal child. Eufaula Adolescent Center's own policies and procedures state they are not equipped to deal with actively suicidal children. David's therapist should have requested that David be treated in a more intense psychiatric setting. They were not authorized to treat a child that was actively suicidal, yet they did nothing to obtain the help that David so desperately needed. As the psychologist assigned to David's treatment team, McBride is equally responsible for providing mental health care

that, in accordance with the Wyatt standards, will provide David an opportunity to be cured or have his mental condition improved. McBride made no adequate efforts to accomplish this. As Plaintiff's expert affidavit states, neither Jurls, McBride, nor Dykes met the most basic minimum professional standards with respect to their administration of Eufaula Adolescent Center or David's therapeutic treatment.

/s/ Kathryn H. Sumrall

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APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 94-6343

Michael Leroy DOLIHITE, Individually and as Father and Next Friend of David Michael Dolihite; Joyce Mary Dolihite, Individually, Plaintiffs-Appellees,

v.

Robert MAUGHON, M.D., Deceased, By and Through Mary FayVIDEON, as Executrix of the Estate of Robert Maughon, M.D.; Royce G. King, Individually; R. Emmett Poundstone, III, Individually; Anthony R. Dykes, Individually; Bradley Mazick, Individually; Karen Jurls, individually; Andrew McBride, Individually; Chester Jenkins, M.D.; Medical Money Management, Inc., Defendants-Appellants, The Alabama Department of Mental Health; Eufaula Adolescent Center; Neuropsychiatry Associates, P.C.; Medical Management, Inc., Defendants.

On Appeal from the United States District Court for the Middle District of Alabama

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[Filed March 21, 1996]

ON PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

Before KRAVITCH, ANDERSON and EDMONDSON, Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ R. Lanier Anderson, III

United States Circuit Judge

APPENDIX G

State of Alabama
Department of Mental Health and Mental Retardation

MEMORANDUM

CONFIDENTIAL

TO: Commissioner Royce King

FROM: Kathy E. Sawyer

RE: Eufaula Adolescent Center

I am writing to bring to your attention again our concerns about the Eufaula Adolescent Center. As you know, we have reported over the years several concerns regarding clinical practices and other treatments of this population as follows:

- use of handcuffs, commonly referred to as hard restraints;
- use of mace;
- placing two or more adolescents in time-out and seclusion rooms together;
- lack of supervision of adolescents placed in time-out; and
- inappropriate use of time-out and seclusion.

Now, in the last week, we have received several investigative reports from BSI and the Facility Advocate that again exemplify our concerns about practices in this facility. While many of these reports date back several months, they reveal the following:

- use of fire extinguishers and fire hoses instead of mace;

— adolescents sodomizing each other while in time-out unknowing to staff;
— adolescents sodomizing each other during bathing, bed time, etc., again unknowing to staff.

To ensure your understanding of the situations and practices I have described, I am enclosing copies of these confidential investigations for your review: Advocacy Case No. 011-0067; BSI Case Nos. M2-8127-91, M2-8078-91, and M2-786-91. Please know that these are just a few examples. I urge you to read these reports in their entirety along with related correspondence.

As an Internal Advocacy Program, we have utilized every strategy available to us to bring about needed changes in these areas. The Department has even hired experts to advise on the Eufaula situation and to make recommendations.

Thus, as our final step in addressing problems in this facility, I am asking you to intervene immediately and take necessary steps to bring about the needed changes in the physical plant, clinical approach, etc. The recommendations of the Experts need to be obtained and immediately put into action. I cannot impress upon you the disservice to those placed in this facility for mental health care and treatment, not to mention the vulnerable and liable situation the Department faces with these non-therapeutic practices.

Should we receive additional reports of this nature, we will forward to you to review. Please know that I am more than happy to discuss this situation with you at your convenience.

cc: Anthony Dykes
Earvie Gandy
R. Emmett Poundstone, III